Clear All Fields

Bridge Application

Alaska Housing FINANCE CORPORATION

Head of Household Printed Name	Telephone Number

To be eligible for the Bridge Process, families must meet minimum qualifying criteria. This form is designed to help you provide information on your family's circumstances to determine if you meet the qualifying criteria and if eligible, determine the type of assistance you may be offered.

1) Do you meet the minimum qualifying criteria? (Answer each question Yes or No)

- ☐ Yes ■ No My family has had a change that significantly impacts my family's income.
- ☐ Yes ■ No The change will last at least 90 days.
- ☐ Yes ■ No The change causes my family to pay more than 50 percent of our monthly income toward rent and tenant-paid utilities.

→ If you answered "**No**" to any of the questions above, **STOP**; you do not appear to qualify for the Bridge Process. If you have questions or would like information on other resources in your community, please contact your local AHFC representative.

→ If you answered "**Yes**" to all questions above, please **complete the rest of this application** and follow all instructions for verifying your family's composition, income, and circumstances.

2) Tell us about the extraordinary change you have experienced. Check the box by the statement that best describes your change **and**, where applicable, provide the additional information requested.

- ☐ One or more family members with income have permanently left my household.
- ☐ My family has experienced an unexpected income loss not related to family members leaving my household.
- ☐ A family member's medical or health condition is preventing a work-able adult from working or is causing a reduction in work hours for a currently employed adult.
- ☐ My family pays more than 50 percent of adjusted monthly income for shelter due to unreimbursed medical expenses (head, spouse or co-head must be at least 62 years of age).
- ☐ My family pays more than 50 percent of adjusted monthly income for shelter due to unreimbursed child care expenses for a child 12 years of age or younger that allows an adult family member to work, search for work, or further his/her education (academic or vocational).
- ☐ Other: None of the above circumstances apply to my family. Please explain the change below

Explain how the change selected in #2 has led to your financial hardship. (If you selected "Other" please first explain the change).

3) **How long do you expect the change** (selected in number 2) **to affect your family's income and ability to pay rent?** Provide both the time frame and reason you expect the change to last for the given amount of time.

4) **What type of hardship relief/assistance are you requesting?** (check only one box)

- ☐ A rent decrease based on reduced income or increased expenses
- ☐ An extension to the five year term limit for participation in the Step program
- ☐ Other: Describe what you are requesting.

5) **How has your family tried to meet its financial needs in response to this change?**

a) We have applied for or are seeking (check all that applies):

- ☐ New or Additional Employment
- ☐ ATAP/TANF
- ☐ Child or Day Care Assistance
- ☐ Child Support
- ☐ Disability benefits (i.e., SSA/SSI/APA)
- ☐ Food Stamps
- ☐ Heating Assistance
- ☐ Jumpstart
- ☐ Other, Explain below
- ☐ Medical Insurance (i.e. Medicaid)
- ☐ Other Counseling or Case Management
- ☐ Unemployment benefits
- ☐ Veteran's benefits
- ☐ Vocational Counseling
- ☐ Worker's Compensation
- ☐ A move to a less expensive unit

b) If you have applied for new income, when do you anticipate the new income to start?

c) If you have not checked any of the options in "a" above, or the attempts you have made are not included in the list, explain what you have done to try to meet your family's financial needs.

6) Is there anything else related to your change in circumstances you feel is important for AHFC or the Bridge Committee to consider? If yes, please explain.

7) Family Composition, Income and Deductions

Each change in circumstance (income source, expense, departure of household member(s), inability to work due to health or medical condition) must be verified. **See the Income and Composition Information page for how to verify each income source, change in family composition, and expense.**

a) If you indicated your family has lost income, complete the chart below to tell us about the lost income.

Family Member Name	Income Source(s)	End Date	Member Left Household?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

b) List all persons **currently** living in your household:

Name	**Age**	**Name**	**Age**

c) List any persons in your household who are over the age of 18 and full-time students:

Name	School Name	Reside at School?
		☐ Yes ☐ No
		☐ Yes ☐ No

d) List all persons living in your household who <u>did not</u> receive the most recent Alaska Permanent Fund Dividend.

Family Member Name	Reason (garnished, not eligible, didn't apply)

e) **Family Income**: Please list all income received by all persons **currently** living in your household. This list should include all monies received each month from all sources (even if AHFC does not count the income when determining annual income).

Name of Family Member Tied to Income	Income Description	Monthly Amt. ($)

f) **Expenses**:

- If you are claiming **medical expenses**, complete the Medical Expense List page of the application and provide verifications as instructed.
- If you are claiming **child care expenses,** complete the table below and provide at least three consecutive receipts for your family's out-of-pocket expenses.

Child's Name	Monthly Amt. ($)

Child Care Provider	Address

g) If a family member's **health or medical condition is preventing a work-able adult from working or is causing a reduction in work hours**, provide the information below so AHFC can verify when the work-able adult will be released to work. **AHFC will not request any personal or confidential information describing a medical or health condition.**

Work-Able Adult Name	Family Member with Health/Medical Condition

Name of Medical Provider for Family Member with Health/Medical Condition

Address

Telephone Number

8) Personal Declaration

a) I do hereby attest that all the information provided in this application about my household members and me is true and complete, and I have read the warning below.

b) I understand that I must report any changes in family composition and income in writing to AHFC within ten (10) business days of the change.

c) In response to an unexpected loss of income, AHFC may offer my family a two month decrease in rent (Safety Net) as part of the preliminary review of my application.
   - o I understand I must enroll and participate in Jumpstart to be considered for any extension of the Safety Net. Jumpstart is AHFC's Family Self Sufficiency Program that assists families who wish to increase income through employment.
   - o I understand work-able adults in the household must be willing to seek and obtain employment or become actively engaged in job training (any adult family member can fulfill this requirement).
   - o Any extensions to a Safety Net will be based on my family's employment barriers and participation in efforts to achieve financial self-sufficiency.

d) All requested documents that verify the change in circumstances, the family income, and family actions are attached.

Warning: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper use of information collected based on the consent form.

Current Mailing Address

Head, Spouse, or Co-Head of Household Signature

Date

Printed Name

Alaska Housing FINANCE CORPORATION

Loss of a Family Member
The family must provide proof of the change in family composition. Examples of verification documents include:

- For family members no longer in the household, provide proof of death, proof of new address, or a statement from the departing household member
- If you are unable to provide one of the above, you may sign a Loss of Family Member Declaration form.

Family Income Loss
For loss of income, the family must provide proof that the income has stopped and date income ended. Verification may include:

- Benefit printout or statement showing end of benefits and reason for end
- Letter from benefit provider showing why and when benefits ended
- For job loss – employment termination letter including date of termination or job layoff notice including last day of work

Current Family Income
The family must provide proof of all income currently received or anticipated within the next 12 months. Samples of verification for various income types are described below.

- Salaries or Wages – letter from an employer that includes start date, rate of pay, work schedule, gross pay to date, etc., **OR** four to six current, consecutive pay stubs that include periodic gross pay amount, year-to-date gross earnings, etc.
- For individuals that are self-employed, the most recent IRS tax filing
- Statements or benefit letters showing the amount and payment schedule for other sources of income such as alimony, Alaska Native corporation payments, annuities, Armed Forces wages, child support, disability income, insurance payments, pensions, retirement account payments, senior benefits, settlements, Social Security, trust payments, unemployment, veteran's benefits, or welfare assistance (ATAP or TANF)

Family Expenses
For each of the following, provide at least three (3) consecutive months of statements or receipts. For expenses claimed so an adult can work, AHFC will not count any expenses that exceed the amount of income earned.

- Out-of-pocket medical expenses, complete the Medical Expense List attached to this form.
- Out-of-pocket expenses the family must pay for childcare for a child (under 13 years of age) so that an adult family member can work or attend school. If the expenses are to allow an adult to attend school, you must also provide proof of enrollment and hours of attendance.

Medical Expense List

1. You may only claim medical expenses if you, your spouse, or co-head is 62 years of age or older.
2. Please see page 2 of this form for a description of the information required.

Expense Category	Estimated Annual Cost ($)
Doctor or other healthcare professional visits (please include any hospital or therapy expenses here)	
Dentist	
Vision or Hearing Aid	
Prescriptions and/or Medicines that have been prescribed by a doctor	
Medical Insurance Payments (AARP, Blue Shield, Blue Cross, etc.)	
Medicare not covered by Public Assistance	
Durable Medical Equipment	
Transportation (trips to the doctor, dentist, etc.) _____ **X** _____ **X** **$0.18** **roundtrip mileage** **number of trips per year** **medical mileage reimbursement rate**	
Total Estimated Annual Expenses $	**$ 0.00**

1. **Please do not provide AHFC with any personal or confidential information describing a medical or health condition**. AHFC collects just the costs or supporting information relating to your medical or health expenses.
2. You may include medical expenses for the entire family.
3. The expenses you list must be regular expenses that you must pay for out of your own pocket. You may not list expenses that are reimbursed or paid for by another source.
4. When documenting expenses, it's what you pay, not what you owe.
5. For each expense category listed, please provide at least three (3) months of receipts or documentation from the appropriate medical source. This may include:
    - Bills or monthly statements from a medical or healthcare provider showing payments and charges
    - A list provided by your pharmacy of your expenses for the last three months
    - Documentation of a payment arrangement with a medical or healthcare provider showing payments made
    - Medicare statements detailing prescription drug costs charged to or paid by the family
    - Credit card statements showing payments made to a medical or healthcare provider
    - If you have general health items listed as part of your expenses (such as vitamins, special toothpaste, or other personal care items), AHFC will need a copy of the prescription for that general health item in order to include it with your medical expenses

    The documentation provided must be sufficient to determine if the expense is eligible and if the family is actually paying for the expense. AHFC may request additional documentation if the family's initial documents are insufficient.